

Narrative based medicine

A narrative approach to mental health in general practice

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There is a tension between the complex narrative that a patient brings into the consulting room and a doctor's understanding of what is really going on as formulated in a diagnosis or an idea about pathology. Which is a "truer" account of reality: the patient's or the doctor's? Can both be true? If so, how?

These questions are particularly relevant in mental health care for a number of reasons. Firstly, sociology and ethnography have identified psychiatry alone among the medical specialties as peculiarly culture bound.^{1,2} Secondly, psychiatry lies in an uncomfortable no man's land between conventional medical science and the search for meaning which may extend into political and religious domains.³ Thirdly, mental health professionals often use confusing and contradictory language to describe their observations. When compared with the babel of explanatory models which often seem to disqualify each other or which may simply be a way of asserting the therapist's power, the patient's own story may gain in authority and seem saner than the professional's version.⁴ Finally, psychiatry is the only area of specialist medicine in which talking and listening are explicitly understood to be therapeutic.⁵

The narrative approach in mental health

In a book on the use of narrative in family therapy, Papadopoulos and Byng-Hall point out an important change in the understanding of what the "talking cure" actually involves⁶: clinicians from many different therapeutic schools are moving away from the search for a normative explanation of someone's problems and towards the search for an appropriate new story for each patient. This change has its origins in modern and "postmodern" intellectual movements, including cybernetics⁷ and structuralism.⁸ For example, the influential American therapists Anderson and Goolishian argue for the need to abandon paradigmatic models that test the patient's experience against some predetermined view of normality.⁹ They propose using an approach that acknowledges the client as an expert and which can facilitate any possible account of reality, provided that it makes sense in the client's eyes. Similarly, Burck refers to selfhood as something to be produced rather than discovered.¹⁰ What all these ideas have in common is that the conversation between clinician and client can no longer be regarded as a tool for seeking out hidden truths. Instead, it should be seen as a means of creating previously unformulated truths.

Is there any place in this anarchic, postmodern universe for facts or professional expertise? Are we not in danger of alienating our psychiatric patients, who surely come to us looking for certainties rather than deconstructions? Many mental health professionals share the dilemma which has been exposed as being at the heart of our work: how do we hold on to our theories and beliefs while allowing the patient's story its full

Summary points

The success of "talking cures" depends on their ability to give coherence to the client's experience of physical or mental illness and to enable the construction of a narrative of healing or coping

The narrative approach to mental health is concerned with the question of how a patient and clinician working together can construct a story that makes sense

In general practice doctors may make useful contributions to patients' stories although these contributions should not be seen as a superior "truth"

This is the second in a series of five articles on narrative based medicine

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opportunity to evolve, even if it does so in directions we might neither expect nor wish?^{11,12}

Using narrative in general practice

I am mainly a general practitioner but I have a special interest in opportunities for mental health work in general practice and teaching.^{13,14} In my clinical work I am aware of narrative in three of its aspects:

- In the familiar role of taking a traditional medical history¹⁵;
- In counselling, as something that needs to be listened to, to allow patients to give coherence to their own history¹⁶; and
- As a therapeutic stance which involves questioning the patient in a way that explores new meanings which may make a difference to the patient.¹⁷

I will address this last aspect in discussing the cases that follow. These cases were selected somewhat at random: they are the stories of the first three patients



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Helen's story

Helen is in her mid-70s. She sees me every month for her high blood pressure. However, we usually deal with the blood pressure quickly because we have other important things to talk about. Helen was widowed about 10 years ago and immediately offered to share her home with an elder sister. Tragically, the elder sister began to develop Alzheimer's disease.

In the years that followed, Helen was torn between her sense of responsibility and an awareness that her sister's needs could break her own health. She battled to keep the situation afloat, and sometimes we fought together for resources against an inadequate welfare system. Eventually, two years ago, Helen's sister went into a nursing home; recently, she died. She had become mute, doubly incontinent, and unable to recognise anyone, although Helen always visited her daily.

You will understand that our consultations are not spent just measuring blood pressure. We talk about Helen's grief and also her relief. She still has some unresolved guilt about putting her sister in a home; who wouldn't? In addition she has a terrible sense of waste: why did her sister have to end her life in this apparently meaningless way? Why has Helen had to spend her own widowhood toiling away desperately so that she now faces her own old age exhausted and quite depressed?

booked to see me in one particular morning surgery. I have altered biographical details to conceal identities.

The first patient was Helen (box). I have intentionally described her case in the manner of a doctor telling the story to colleagues, not as one might present a psychiatric case history in a journal. So it is already in a narrative rather than a paradigmatic form. It ranges longitudinally over a period of years rather than just giving a snapshot of one moment. It involves not just the patient but also the social system that surrounds her: her family and state agencies. It moves indiscriminately between the domain of the mind and that of the body. I am present in the story as an agent. This is my narrative of Helen's narrative; she might tell it differently. It is the stuff of general practice but it is framed predominantly in biographical rather than pathological terms.¹⁸

Narrative and diagnosis

One question I have to struggle with is this: is Helen "suffering from depression?" How do I hold up the predetermined, quasiscientific template of psychiatric diagnosis against my personal reading of Helen's story? General practitioners, like all clinicians, are under pressure to make a diagnosis—under pressure from our training, from managers, from the journals that bombard us with information, and from institutions like the royal colleges which exhort us to "defeat depression." Yet a diagnosis is actually no more than a linguistic construct. It is often designed for the needs of one profession but it may serve others' needs inadequately or not at all.¹⁹ Used thoughtfully, a diagnosis can be a convention that helps the doctor to help the patient. Used without thought, it can become a tool for fending off a doctor's anxiety. It may also distract attention from parts of the patient's story that might create cognitive dissonance for the doctor.

One solution to this challenge is to see my work not just as listening to Helen, nor just as formulating diagnoses, but to see it as asking questions which explore a better story: the story of Helen not as a person in decline who has failed and thus become a psychiatric case but of a conscientious sister who did her best when faced with a terrible dilemma. This type of exploration does not preclude offering Helen the diagnosis of reactive depression or even suggesting treatment with antidepressant drugs. However, if I do these things I want to do them collaboratively, trying to find out if such suggestions fit Helen's view of her story even when she expressly concedes authority to me.²⁰

Narrative and serious mental illness

Seeing Rustem (box) makes me wonder, half ironically, if his mental health problem is "serious." On the one hand, I might say that it is not terribly serious because there is no obvious psychosis nor are there even any biological features of depression. On the other hand, Rustem may be a worrying candidate for suicide given his age, his impending divorce, his unemployment, his history of violence, and his drug habit. So how are we to judge the seriousness of the stories we hear and take part in?

Seen in terms of the complex, poignant narratives in which many doctors participate daily, it is easy to be sceptical about the way the mental health community divides its workload into those clients with "serious pathology" and those classed as the "worried well." This trivialises much of our work. Also, these classifications may become self fulfilling prophecies. If clinicians compartmentalise their clients' narratives so that the categories of psychotic and violent are cut off from their familial and social contexts, clinicians run the risk of amplifying exactly the problems they are trying to solve. For example, once someone is labelled as having

Rustem's story

Rustem is Iranian, in his 50s, and recently out of prison where he served five years for grievous bodily harm. While he was in prison his wife started divorce proceedings. In spite of this, they are currently living together since he has nowhere else to go. I look after all the family so I was involved when Rustem's mother died from cancer four years ago, and I had to arrange for him to have compassionate leave from prison so he could visit her on her deathbed. He visited her in handcuffs.

I have also seen a lot of Rustem's wife and sons. They have talked about the shame and the economic consequences of having a husband and a father who is a convicted criminal. Incidentally, Rustem's wife is a seamstress and each Christmas she makes and brings me a pair of trousers.

Rustem came out of prison addicted to heroin. I see him fortnightly to prescribe methadone. However, Rustem also has major medical problems, including quite severe rheumatoid arthritis, and I am trying to sort these out too. It is hard because Rustem has difficulty with English, and I cannot manage to clarify one problem before he moves onto the next. I speak no Farsi. In spite of my sympathy for his wife, I believe that he has been deeply traumatised by his stay in prison and is depressed. I do not know how he will deal with the divorce and his probable eviction from the family home.

Sheryl's story

I was originally asked to see 3 year old Sheryl and her mother by one of our health visitors. The mother is sometimes a lone parent, sometimes not. Her relationship with Sheryl's father is a violent one. Sheryl has major behavioural problems: she hits her mother and also the other children in her school. She shouts and screams and bites.

Both Sheryl and her mother have had some involvement with social services and the local child guidance clinic but nothing has helped. They fail to engage with the help that is offered, or sometimes it seems to work for a brief time and then they disengage. After each intervention the mother returns to my surgery with Sheryl to ask if there is any other approach she can try. A year ago I arranged for a placement at the local family centre, where I hoped they would be able to do some structured family work. However, Sheryl's mother had to work during the day so this too failed as an intervention.

Recently, against the wishes of all the agencies involved, Sheryl's mother requested a referral to an expert on attention deficit hyperactivity disorder in the hope that Sheryl's problems could be solved by drug treatment.

schizophrenia we may stop trying to have normal conversations with them about their lives, and thus may contribute further to a process of marginalisation.

Narrative and medical interventions

My main difficulty with Sheryl's story (box) concerns the idea of finding treatment or solutions. All general practitioners and all mental health workers are under enormous pressure to deliver cures, preferably at great speed. Yet my own understanding of Sheryl's story is that it does not invite quick solutions. It has evolved out of a matrix of genetic, familial, and social influences, together with moral choices and fate. Her mother believes that there is an instant cure just around the corner. I believe that my long term role will probably be as a constant figure among a shifting community of professional carers, able to tolerate this family's cycle of unrealistic hopes and subsequent disappointments. Whose narrative is "right," mine or Sheryl's mother's?

One way to respond to this question is by refusing to be wedded to either person's narrative—either the narrative created by her mother's impulsive optimism or that created by my own rather fatalistic view. I am prepared to make referrals to a specialist in attention deficit hyperactivity disorder as requested by Sheryl's mother, even when it goes against my own beliefs or instincts. At the same time, I have to allow myself to realise that there may well be social, economic, and other forces that make any hope for a different story rather fanciful. Others, including the specialist in hyperactivity disorder, may disagree.

Conclusions

These cases highlight the difficulties posed by attempts to reframe mental health issues as stories. The story telling approach may collide rather violently with concepts imported from positivist, "objective" viewpoints. Narratives are not necessarily about categorisation; they may be about a lack of boundaries. Clinicians who stand at

the intersection between the world of stories and the world of categorisation, between the role of interpreter and the World Health Organisation's ICD-10 (international classification of diseases, 10th revision), may well feel that they are in an impossible position.

One possible route away from this dilemma may be offered by social constructionism.²¹ According to pure social constructionism, all types of knowledge—including professional knowledge—can be seen as stories that are negotiated among ourselves as agreed versions of reality, often as a means of exerting power. However, a less fundamentalist version of constructionism accepts that some stories may approximate to testable scientific reality, although they can never quite reach it. What characterises this view, therefore, is not a rejection of medical activity in the name of interpretive purity but an acceptance of the partnership between patient and doctor in exploring, creating, and testing the efficacy of new stories.

Seen in this light, the medical consultation becomes an opportunity for dialogue between different stories: the patient's biographical one and the doctor's professional one. The doctor's contributions may come in different forms, including interpretations about the family origins of a problem or a conventional biomedical story (for example, an account of the genetics and biochemistry of schizophrenia). Indeed, if mind and body are seen as interactive, then all medical interventions—even psychopharmacology—can be seen as an agreed intervention into patients' "storying" of themselves. The doctor's contribution to the story is valuable not as a truth which has prior and superior validity to the patient's truth but only if the patient finds the doctor's contributions to the plot useful.

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